

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

CERTIFICATE OF DEATH

Reg. Dist. No.

10470
24

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 3 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 630 N. Milton Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Barbara First Bangert Middle Bangert Last		4. DATE OF DEATH Month October Day 11 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-70
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph H. Laven	
14. MOTHER'S MAIDEN NAME Mary H. Kempal		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sophie Cihlar Address 524 N. Hilton Ave, Balto	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 month 11 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS' arr. w/ disturbance of metabolism, growth + nutrition with			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stroke brain disease	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 2, 1954 to October 11, 1957 , that I last saw the deceased alive on October 11, 1957 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude Sourenfeldt M.D. Springfield State Hospital Sykesville		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Gertrude Sourenfeldt M.D. Springfield State Hospital Sykesville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-18-1957	22c. NAME OF CEMETERY OR CREMATORY 1404 REDEEMER	22d. LOCATION (City, town, or county) (State) BALTO. MD
23. FUNERAL DIRECTOR'S SIGNATURE F.R. CVIACI + SON 900 N. CHESTER ST		24a. REC'D BY REGISTRAR DATE 14 1957	24b. REGISTRAR'S SIGNATURE Cherry Wees

CERTIFICATE OF DEATH

REG. CODE 20

Name of Deceased Joseph R. ...		Sex Male		Age 8-10-72		Date of Death October 11, 1957	
Place of Birth ...		Usual Residence ...		Cause of Death ...		Manner of Death ...	
Physician's Signature ...		Hospital or Institution ...		Medical Examiner's Signature ...		Registrar's Signature ...	
Date of Report ...		Signature of Reporting Physician ...		Signature of Medical Examiner ...		Signature of Registrar ...	

BUREAU V. 2

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10472 CERTIFICATE OF DEATH

104721

Reg. Dist. No.

3374

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown <i>03X2.2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION May Pullen Nursing Home				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Gore Last Beveridge				4. DATE OF DEATH Month October Day 1 Year 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hilleary B. Gore				14. MOTHER'S MAIDEN NAME Rebecca Conaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Marion B. Gore Westminster Md RD 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery, Cardiac failure, 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Myocardial infarction. (c) Chronic Arterial Syndrome.						INTERVAL BETWEEN ONSET AND DEATH April 57 to Oct 57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19, to Sept 1957 , that I last saw the deceased alive on 1 Oct 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall				ADDRESS (Street, city or town, state) Reisterstown Md		DATE SIGNED Oct 1 1957	
PHYSICIAN'S NAME (Type) Dr. J. B. Berryman + Sons							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 4 1957		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Berryman + Sons				24a. REC'D BY REGISTRAR DATE 10-1-57		24b. REGISTRAR'S SIGNATURE Harry B. Shive <i>C. Harry Shive</i>	

RECEIVED

10473

CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD. 3 WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WETZEL NURSING HOME</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>ELIAS</u> First <u>BOLLINGER</u> Middle <u>BOLLINGER</u> Last				4. DATE OF DEATH <u>10-27-1957</u> Month <u>10</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16-1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GHIO</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>	
13. FATHER'S NAME <u>WILLIAM BOLLINGER</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA STUMP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>JACOB BOLLINGER</u> Address <u>R. D. 3 WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 10, 1957</u> , to <u>Oct 27, 1957</u> , that I last saw the deceased alive on <u>Oct 27, 1957</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>85 1/2 W. Green St. Westminister, MD.</u> DATE SIGNED <u>10/28/57</u>							
ACTUAL SIGNATURE <u>Julius Chepko</u>				PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10-30-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WAYNE CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>WOOD CO. OHIO</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>David A Bankard</u> ADDRESS <u>Westminister, Md</u>			
24a. REC'D BY REGISTRAR <u>Harriet Miller</u>				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 31 1957

RECEIVED

10474

CERTIFICATE OF DEATH

Reg. Dist. No. 33 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7yrs. 11mos. 7days x 2. Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Blanche Last BOSLEY				4. DATE OF DEATH Month October Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1886	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Bosley				14. MOTHER'S MAIDEN NAME Angelin Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of stomach due to ulcer 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaphragmatic hernia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							INTERVAL BETWEEN ONSET AND DEATH Acute Congenital
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month July Day 1 Year 1950 Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital		(County) Carroll		(State) Md
21. I certify that I attended the deceased from July 1, 1950 to October 9, 1957 , that I last saw the deceased alive on October 9, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		M.D. Springfield State Hospital		DATE SIGNED 10/10/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Finksburg Methodist	22d. LOCATION (City, town, or county) (State) Finksburg, Carroll, Md				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons		ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR 10-12-57	24b. REGISTRAR'S SIGNATURE Harry S. Stine Chas. H. Hays		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group and the experimental group. The control group was divided into two subgroups: the control group and the experimental group. The experimental group was divided into two subgroups: the control group and the experimental group.

OCT 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10475 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10474
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2, Md 3 v o l 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 29 Albermarle Street	
3. NAME OF DECEASED (Type or print) First Rubin Middle Botwinik Last Botwinik		4. DATE OF DEATH Month 10 Day 26 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57	IF UNDER 24 HRS. Days 57 Hours 57 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dye		10b. KIND OF BUSINESS OR INDUSTRY Maryland Russia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul		14. MOTHER'S MAIDEN NAME Miriam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKN		16. SOCIAL SECURITY NO. UNKN	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerotic heart disease years INTERVAL BETWEEN ONSET AND DEATH minutes minutes years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych. rea ct. Chronic nephritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-19-57 , 19 19 , to 10-26 , 19 57 , that I last saw the deceased alive on 10-26 , 19 57 , and that death occurred on 10-26 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 10-26-57			
ACTUAL SIGNATURE Edmund Lusthaus		PHYSICIAN'S NAME (Type) Edmund Lusthaus	
22a. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or county) (State) Baltimore Md	
22b. DATE THEREOF 10-27-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc		24a. REC'D BY REGISTRAR 10/26/57	
24b. REGISTRAR'S SIGNATURE C. Henry		24c. REGISTRAR'S SIGNATURE C. Henry	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 3

OCT 29 1957

RECEIVED

10476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b Lyrs. 7 mos. 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore <i>3v01.4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3714 Kimble Road, Zone 18		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Genevieve Estelle Gill BRADLEY				4. DATE OF DEATH Month Day Year October 14, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1873	
9. AGE (In years lost birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown Charles GILL				14. MOTHER'S MAIDEN NAME Unknown Alice Ridgely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) City		20h. (State) Md	
21. I certify that I attended the deceased from March 4, 1953 to October 14, 1957 , that I last saw the deceased alive on October 14, 1957 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/15/57 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY MORELAND PARK		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Rd		24a. REC'D BY REGISTRAR DATE 10/15/57	
24b. REGISTRAR'S SIGNATURE L. Harry Keer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION

Form 100-101

DATE OF DEATH

PLACE

TIME OF DEATH

PLACE

DATE OF BIRTH

PLACE

TIME OF BIRTH

PLACE

DATE OF DEATH

PLACE

TIME OF DEATH

PLACE

DATE OF BIRTH

PLACE

TIME OF BIRTH

PLACE

DATE OF DEATH

PLACE

TIME OF DEATH

PLACE

DATE OF BIRTH

PLACE

TIME OF BIRTH

PLACE

DATE OF DEATH

PLACE

TIME OF DEATH

PLACE

DATE OF BIRTH

PLACE

TIME OF BIRTH

PLACE

DATE OF DEATH

PLACE

TIME OF DEATH

PLACE

BUREAU V. 3

OCT 16 1957

RECEIVED

CERTIFICATE OF DEATH

10477

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN IB 2 mths 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.	
3. NAME OF DECEASED (Type or print) First Francis Middle Joseph Last Burger		4. DATE OF DEATH Month 10 Day 5 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 - 21 - 85
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary engineer		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 72 yrs.
10. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Louis Burger		13. MOTHER'S MAIDEN NAME Mary Carroll	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		15. SOCIAL SECURITY NO. 215-03-2860	
16. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 492x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych. react. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 7 - 8 - 1957 , to 10 - 5 - 1957 , that I last saw the deceased alive on 10-5-1957 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Edmund Lusthaus ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-6-57 PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Maryland. 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 10/9/57 22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL 22d. LOCATION (City, town, or county) (State) BALTO - 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DATE 10/1/57 24a. REC'D BY REGISTRAR C. Harry Keys 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1882		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 Main St., Boston		Carpenter		Heart Disease		Natural		Oct 10, 1957		Home	
Physician		Hospital		Burial		Cremation		Date of Burial		Place of Burial	
Dr. J. A. Smith		St. Mary's		Buried		Cremated		Oct 15, 1957		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Undertaker		Signature of Burial Director	
J. A. Smith		J. B. Jones		J. C. Smith		J. D. Jones		J. E. Smith		J. F. Jones	

BUREAU V. S.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10477
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 5yrs. 7mos. 2days				d. STREET ADDRESS 127 S. Schroeder St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last May Ray Harris CARUSO				4. DATE OF DEATH Month Day Year October 9, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailoring Co.		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Harris				14. MOTHER'S MAIDEN NAME Frances Guy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic Aortitis involving coronary arteries DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis.						INTERVAL BETWEEN ONSET AND DEATH hours years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was found on floor by bed unconscious.					
20c. TIME OF INJURY Month, Day, Year 7:30 AM o. m. 10/9/57 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/10/57	
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12/57		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. A. WITKE				ADDRESS 4101 F. D. M. Ave BAL. MD.		24a. REC'D BY REGISTRAR OCT 15 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Myers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

10479

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. (rural)				c. LENGTH OF STAY IN 1b 1½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Giallobardo Crivella				4. DATE OF DEATH Month October Day 5 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1888		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A. (naturalized)							
13. FATHER'S NAME Mario Giallobardo (deceased)				14. MOTHER'S MAIDEN NAME Mary Grace Ditta (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not known		17. INFORMANT Address Washington, D. C. Josephine LaMendola, 3955 Blaine St., N. E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart Disease (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from May 4, 1956 , to Oct. 5, 1957 , that I last saw the deceased alive on Oct. 5, 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md. DATE SIGNED							
ACTUAL SIGNATURE Gertrud Sourenfeldt M.D.							
PHYSICIAN'S NAME (Type) Gertrud Sourenfeldt M.D. Springfield State Hospital Sykesville Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-9-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon				ADDRESS 3831 - La Ave NW		24a. REC'D BY REGISTRAR DATE 8 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Heers			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

900 8 1957

RECEIVED

10480

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 4,751 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 1326 Myrtle Avenue			
3. NAME OF DECEASED (Type or print) First Jane Middle Elizabeth Last Day				4. DATE OF DEATH Month October Day 18 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1941	
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James E. Day				14. MOTHER'S MAIDEN NAME Nancy Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Nancy Day - Mother - 1326 Myrtle Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitary pulmonary Tbc. 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor Pulmonale DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 13 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15- , 19 44 , to 10-18 , 19 57 , that I last saw the deceased alive on 10-18 , 19 57 , and that death occurred at 2 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 10-18-57							
ACTUAL SIGNATURE E. M. Maculans M.D.				PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D. Supt. Henryton State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell				24a. REC'D BY REGISTRAR Pikeville, Md.		24b. REGISTRAR'S SIGNATURE Albert R. Swann	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

• • • • •

BUREAU V. S.

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10480

Reg. Dist. No.

10481

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yrs. 1mo. 21days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 532 E. North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Estelle Middle Viola Last DEVEREAUX			4. DATE OF DEATH Month October Day 15 , Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropodist		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael Devereaux			14. MOTHER'S MAIDEN NAME Elizabeth Crane		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease DUE TO (b) Bronchopneumonia DUE TO (c) Senile psychosis with simple deterioration and generalized arterio-sclerosis. Intertrochanteric fracture, right femur. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 416X 491X					INTERVAL BETWEEN ONSET AND DEATH Years 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis with simple deterioration and generalized arterio-sclerosis. Intertrochanteric fracture, right femur.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown			
20c. TIME OF INJURY Month, Day, Year Hour 2:PM o. m. 10/7/57 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Sykesville		20g. (County) Carroll		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James T. Marsh			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James T. Marsh, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/18/57		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL	
22d. LOCATION (City, town, or county) BALTO.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Frederick J. Low Baltimore & Co.			24a. REC'D BY REGISTRAR DATE 10/18/57		24b. REGISTRAR'S SIGNATURE C. Harry Myers

M

15

I

2

2

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

1 10482 10481 15 1 06 2 44 VS. A15ME(5) SM 9/55 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal. 10482 10481 15 1 06 2 44 VS. A15ME(5) SM 9/55 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10482 10481 15 1 06 2 44 VS. A15ME(5) SM 9/55 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
c. LENGTH OF STAY IN 1b <u>1yr. 12days</u>				d. STREET ADDRESS <u>838 Abbott Court, Balto. 2.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Bonn</u> Last <u>Ferris</u> <u>DEWLING</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10,</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. RELATION TO DECEASED <u>WIDOWED</u>		8. DATE OF BIRTH <u>October 1, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Ferris</u>				14. MOTHER'S MAIDEN NAME <u>Anna Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-5304</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>904.7</u> (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile brain disease with psychotic reaction.</u> <u>Fracture of left femur.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE OF DEATH. PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> <u>Slipped and fell.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/3/57</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>No</u>		20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am J. Dickner & Sons. Balto</u>				ADDRESS <u>17</u>		24a. REC'D BY REGISTRAR DATE <u>11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry Kern</u>			

OCT 11 1957

RECEIVED

CERTIFICATE OF DEATH

10482

Reg. Dist. No. 76 A

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills Md</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>Hampstead x 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS - HAVERN GILL</u>				4. DATE OF DEATH Month Day Year <u>Oct 19 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>aug 17 - 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>R Stephen Gill</u>				14. MOTHER'S MAIDEN NAME <u>Aurice Six</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-12-2411</u>		17. INFORMANT <u>Mrs Wm Auer</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aneurysm Aorta</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis C-V disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-23</u> 19 <u>57</u> , to <u>10-19-57</u> , that I last saw the deceased alive on <u>10-19</u> 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>105 E Main St</u> DATE SIGNED <u>10-19-57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				<u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>Oct. 22. 57</u>		24b. REGISTRAR'S SIGNATURE <u>Louise M. Enigh</u> <u>Deputy Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 24 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10483

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u>	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Union Mills</u>	LENGTH OF STAY (in this place) <u>7 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Meadow View Nursing Home</u>	STREET ADDRESS (If rural give location) <u>Main Street</u>		
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rembert DeCarroll Gore</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 15 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 17 1878</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md State Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis D Gore</u>		14. MOTHER'S MAIDEN NAME <u>Martha E Frazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Mrs Inez C Horine RFD 5 Westmins</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442x IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease</u>		<u>Sept 30/57</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C Hypertension & arteriosclerosis</u>		<u>Several</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Multiple Bed Sores</u>		<u>yes</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Left Hip</u>		<u>May 19 57</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19 56</u> , to <u>Oct 15 57</u> , that I last saw the deceased alive on <u>Oct 14 19 57</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. L. Speicher</u> M.D.		ADDRESS (Street, city, town, state) <u>Westminster Md</u>	
DATE SIGNED <u>10/15/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 18 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
24. REC'D BY REGISTRAR DATE <u>10-15-57</u>		REGISTRAR'S SIGNATURE <u>Anna B. Straub</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman & Sons</u>		ADDRESS <u>Reisterstown Md</u>	

RECEIVED

OCT 22 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE 18 1000

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

NOTED
RECEIVED
OCT 22 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10485

CERTIFICATE OF DEATH

Reg. Dist. No.

10484

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE x2 RURAL</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN DENNIS MAHN</u>				4. DATE OF DEATH Month Day Year <u>OCT 27 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 25 - 1953</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. AGE (In years last birthday) <u>4</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>FRANKLIN D HAHN</u>			
14. MOTHER'S MAIDEN NAME <u>FLORA FRANCIS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>FRANKLIN MAHN</u> Address <u>RURAL UNION BRIDGE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute laryngo-tracheo-bronchitis</u> DUE TO (c) <u>Upper Respiratory Infection</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>OCT 26</u> , 1957, to <u>OCT 27</u> , 1957, that I last saw the deceased alive on <u>OCT 26</u> , 1957, and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>E. Imbler Thompson M.D.</u>				<u>Townsend, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 29 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAUGHS</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons Union Bridge</u>				ADDRESS <u>Union Bridge</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Philip J. Keps</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 29 OCT

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10486

CERTIFICATE OF DEATH

10485 74
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1468 William Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Hawk</u> Last <u>Hawk</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unkn Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Hawk</u>				14. MOTHER'S MAIDEN NAME <u>Ella Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>yes Navy</u>		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>S.S. Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubitus ulcers</u> DUE TO (c) <u>Decubitus ulcers</u>						INTERVAL BETWEEN ONSET AND DEATH weeks weeks weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. brain syndr. assoc. with Huntington chorea, with psych. reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-29-55</u> , 19 <u>55</u> , to <u>10-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>10-4-57</u>							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>				M.D. <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>				24a. REC'D BY REGISTRAR DATE <u>10-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Keep</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		OCT 9 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	
ZIP CODE		CENSUS TRACT	
21201		100-100	
BLOCK		LOT	
100		100	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	
ZIP CODE		CENSUS TRACT	
21201		100-100	
BLOCK		LOT	
100		100	

BUREAU V. 1

OCT 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10487 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10521 *g v*

Item 8, Film G-222-11/12/57

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3241 Thomas St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EUNICE ELY HUBBARD		4. DATE OF DEATH Month Day Year OCT. 26, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1891
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edwin N. Ely		14. MOTHER'S MAIDEN NAME Blanche Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-28-5654	
17. INFORMANT Mrs. Marion Harris, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 25, 1957 , to OCT 26, 1957 , that I last saw the deceased alive on OCT 25, 1957 , and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. M. Van Poole M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Mt. Airy Md 10-26-57	
PHYSICIAN'S NAME (Type) C. M. Van Poole			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-29-1957	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR OCT 29 1957		24b. REGISTRAR'S SIGNATURE Edna Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES THOMAS		M		45		1912		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
LABORER		HEART DISEASE		NATURAL		1957		BALTIMORE, MARYLAND	
EDUCATION		SCHOOLING		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
HIGH SCHOOL		8 YEARS		METHODIST		MARRIED		NONE	
SPECIAL OCCASIONS		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
NONE		1957		10:00 AM		10:00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. [Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488

CERTIFICATE OF DEATH

10488

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Md. (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>205 W. Madison St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Hunt</u> Last <u>Hunt</u>				4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1862</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Martha Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT <u>Wm. Wright, trustee 2860 20th st. West,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosclerosis arteriosclerotic heart disease</u> DUE TO (c) <u>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>reaction.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>8-22</u> , 19 <u>56</u> , to <u>10-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>57</u> , and that death occurred at <u>3</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerhard Souwerfeldt</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital Sykesville Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gerhard Souwerfeldt M.D.</u>				DATE SIGNED <u>10-9-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc. 1217 St. Paul St.</u>				24a. REC'D BY REGISTRAR <u>10-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Tiller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 14 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF FUNERAL HOME	
14. SIGNATURE OF BURIAL PLACE	
15. SIGNATURE OF OTHER	
16. SIGNATURE OF OTHER	
17. SIGNATURE OF OTHER	
18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER	
20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER	
23. SIGNATURE OF OTHER	
24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER	
26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER	
30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER	
32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER	
38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER	
42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER	
44. SIGNATURE OF OTHER	
45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER	
47. SIGNATURE OF OTHER	
48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER	
50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER	
53. SIGNATURE OF OTHER	
54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER	
57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER	
59. SIGNATURE OF OTHER	
60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER	
62. SIGNATURE OF OTHER	
63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER	
68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER	
72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER	
74. SIGNATURE OF OTHER	
75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER	
78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER	
80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER	
83. SIGNATURE OF OTHER	
84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER	
86. SIGNATURE OF OTHER	
87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER	
90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER	
92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER	
96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER	
98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10487

CERTIFICATE OF DEATH

Reg. Dist. No.

87483

10489

1. PLACE OF DEATH o. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine, Md.			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gosnell Nursing Home				d. STREET ADDRESS 6525 Maplewood Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUISE Middle H. Last JACOB				4. DATE OF DEATH Month Oct Day 7 Year 1957				
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1862		9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bartell				14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mamie Leiman, 4803 Frederick Avenue				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, Cardiac failure, 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease, Abnormal DUE TO (c) Aneurysm.							INTERVAL BETWEEN ONSET AND DEATH 1956 to Oct 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1956 , 19 7 Oct , to 7 Oct , 1957, that I last saw the deceased alive on 7 Oct , 1957, and that death occurred at 10:45 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Howard E. Hill				ADDRESS (Street, city or town, state) Spheerille, Md				
PHYSICIAN'S NAME (Type) William Cook, Inc., 1217 St. Paul Street				DATE SIGNED 7 Oct 57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 10/9/57		24b. REGISTRAR'S SIGNATURE Edna Kewitz		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

BUREAU W. B.

OCT 10 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The death certificate copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10488

Reg. Dist. No. 76

10490

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Finksburg</u> <u>Carroll</u> <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Finksburg,</u>		<u>8 years</u>		TOWN <u>Finksburg, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Finksburg, Maryland</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frances Evelyn Jones</u>				<u>10 - 16 - 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>9-11-1877</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Carroll Co. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis W. Reese</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Coppersmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Thomas S. Jones Finksburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis 12 hours</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-11-52</u> to <u>10-16-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>57</u> , and that death occurred at <u>4:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strodel</u>				ADDRESS (Street, city, town, state) <u>48 Main Street Reisterstown, Maryland</u>			
M.D. <u>10-16</u>				DATE SIGNED <u>10-16</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-19-57</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westminster, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Mullin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>8-18-57</u>							

CERTIFICATE OF DEATH

New York City

I, the undersigned, being a duly qualified physician, do hereby certify that

the above named person died on the 21st day of October, 1957, at the residence of the deceased, 1000

Baltimore, Maryland.

1000

at the residence of the deceased.

Cause of death

1000 - 1000

1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

BUREAU V. 2

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10491

CERTIFICATE OF DEATH

Reg. Dist. No. 104894

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>2623 Guilford Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cecelia Geneveive King KANE</u>				4. DATE OF DEATH Month Day Year <u>October 24, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1870</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas King</u>				14. MOTHER'S MAIDEN NAME <u>Sara Conroy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4200</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 26, 1957</u> , to <u>October 24, 1957</u> , that I last saw the deceased alive on <u>October 23, 1957</u> , and that death occurred at <u>5:15 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>10/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc 1517 N. Paul St.</u>				24a. REC'D BY REGISTRAR DATE <u>10-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

OCT 28 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bag of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 1mo. 4days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1615 N. Pulaski Street, Zone 17	
3. NAME OF DECEASED (Type or print) First William Middle Frederick Last KEISER, Jr.		4. DATE OF DEATH Month October Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 3, 1899
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 3 Days 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Truck	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Keiser		14. MOTHER'S MAIDEN NAME Elizabeth(Keiser) Polheim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 744	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH minute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide by hanging.	
20c. TIME OF INJURY Month, Day, Year 5:20PM. 10/29/ 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Sykesville Carroll Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Marital causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 10/29/57	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-2-57	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE 10/30/57	
		24b. REGISTRAR'S SIGNATURE C. Harry W...	

M

15

I

0

0

2

10/29/57

RECEIVED

OCT 24 1957

BUREAU VI A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 9, Film G221, 10/24/57, fcy
10493
10491 75
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester (Rural)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester - Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>JOHN-LOUIS - KNIGHT</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>12</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 21, 1906</i>
9. AGE (In years last birthday) <i>Ap. 51 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John L Knight</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Prieschel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>225-05-0485</i>	
17. INFORMANT <i>Madeline Knight, Manchester, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Left Lung</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/26</i> , 1957, to <i>10/12</i> , 1957, that I last saw the deceased alive on <i>10/7</i> , 1957, and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Foward</i>		DATE SIGNED <i>10/12/57</i>	
PHYSICIAN'S NAME (Type) <i>W. H. Foward M.D.</i>		ADDRESS (Street, city or town, state) <i>Manchester, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10.14.57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wesleyan Mch. School</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Tipton</i>		24a. REC'D BY REGISTRAR <i>10/14/57</i>	
ADDRESS <i>Newspitead Md</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs M H P...</i>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10492

10494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Westminster d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Flora Ida Koontz		4. DATE OF DEATH Month Day Year October 16, 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1865
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Valentine C. Wentz		14. MOTHER'S MAIDEN NAME Lydia Harman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bertha Myers, Westminster, Md. R.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Coronary Vascular Renal Disease DUE TO (c) 24 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ball Bladder Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. YEARS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1954 to Oct 16, 1957 that I last saw the deceased alive on Oct 16, 1957 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Allen Moulton PHYSICIAN'S NAME (Type) G. ALLEN MOULTON, M.D. WESTMINSTER, MD.		ADDRESS (Street, city or town, state) 148 W Main, Westminster DATE SIGNED 10/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/57	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Valley, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mervyn C. Fuss ADDRESS Taneytown, Maryland		24a. RECEIVED BY REGISTRAR Oct 21 1957 DATE 24b. REGISTRAR'S SIGNATURE Assant Mullen	

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1049376

10495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Lawyer</u>			4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Lawyer</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-0791</u>		17. INFORMANT <u>Mrs. J. William Lawyer, Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (3rd)</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis (chr) nephritis (chr)</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May, 1945</u> to <u>10-30-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10-30-</u> 19 <u>57</u> , and that death occurred at <u>6</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. C. Smith</u>				ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. C. Tennant</u>				DATE SIGNED <u>11-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Merwyn C. Fuss, Taneytown, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS MARRIAGES	
SPECIAL INQUIRY		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

NOV 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 10494 74

10496

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 24, Md. 34014			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 125 Cheapside Syreet			
3. NAME OF DECEASED (Type or print) First Robert Middle Leslie Last Maddox				4. DATE OF DEATH Month 10 Day 18 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-28-01		9. AGE (In years lost birthday) yrs. 55	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) welder			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Maddox				14. MOTHER'S MAIDEN NAME Ana Mc Clellan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1921-22 218-05-0571		17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced Pulmonary Tuberculosis DUE TO (c) Chr. brain syndr. assoc. with centr. nerv. system syphilis, meningoencephalitic with psychotic reaction							INTERVAL BETWEEN ONSET AND DEATH days years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16-1956 , to 10-18-1957 , that I last saw the deceased alive on 10-18-1957 , and that death occurred 8:19 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-19-57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/57		22c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMT		22d. LOCATION (City, town, or county) (State) BALTO. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann				24a. REC'D BY REGISTRAR 3218 Hudson St		24b. REGISTRAR'S SIGNATURE Harry Myers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1957

RECEIVED

DATA

ТМТ) ЯЗЗН-003

1954-55

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Ib 3 mos. 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1212 W. 37th St., Zone 11		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Allen Last MILLER				4. DATE OF DEATH Month October Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1880	
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Miller				14. MOTHER'S MAIDEN NAME Susan Miller** Masenheimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 513-05-0502		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 491X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to cerebral arteriosclerosis, plus psychosis HYPERTENSION 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957 , to October 23, 1957 , that I last saw the deceased alive on October 23, 1957 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				DATE SIGNED 10/23/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden)		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Verner				24a. REC'D BY REGISTRAR 4611 Park Heights			
ADDRESS 4611 Park Heights				24b. REGISTRAR'S SIGNATURE C. Verner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

OCT 25 1957

RECEIVED

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

78

10499

FOR STATE
HEALTH DEPT.
M

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster		c. LENGTH OF STAY IN lb 15 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First JESSE Middle EARL Last MORGAN		4. DATE OF DEATH Month OCT. Day 2, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Morgan		14. MOTHER'S MAIDEN NAME Fannie Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-14-4528	
17. INFORMANT Mrs. Matilda Morgan,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James J. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-5-1957	
22c. NAME OF CEMETERY OR CREMATORY Poplar Springs		22d. LOCATION (City, town, or county) (State) Howard Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR OCT 4 1957		24b. REGISTRAR'S SIGNATURE E. M. Harvey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT.

RECORDED

BUREAU V. S.

OCT 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10500

CERTIFICATE OF DEATH

10498

Reg. Dist. No. *14*

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park <i>15122</i>		
c. LENGTH OF STAY IN 1b 2yrs. 7mos.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS 609 Sligo Creek Parkway		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Kate Middle Nave Last MURPHY			4. DATE OF DEATH Month October Day 14 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1870		9. AGE (In years last birthday) 87 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Christian Addison Nave			14. MOTHER'S MAIDEN NAME Ella Mathers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. <i>unk</i>		
			17. INFORMANT Springfield Hospital Records		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction, Cellulitis, left knee.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	--

20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 14, 1955 , to October 14, 1957 , that I last saw the deceased alive on October 14, 1957 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/14/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF 10-16-57	22c. NAME OF CEMETERY OR CREMATORY <i>Shout Lincoln</i>	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR DATE 10-15-57		24b. REGISTRAR'S SIGNATURE <i>C. Harry Eber</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALL DEATHS

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OTHER OFFICIALS	

CERTIFICATE OF DEATH

Reg. Dist. No. 174

10501

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>6 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fuller Nursing Home</u>				d. STREET ADDRESS <u>BALTO 20 MD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA BRITTON PIERCE</u>				4. DATE OF DEATH Month Day Year <u>October 20 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/28/1861</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>HOLLAND, NEW JERSEY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HENRY T. BRITTON</u>				14. MOTHER'S MAIDEN NAME <u>MAHALIA BRITTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOHN D. PIERCE (SON) 7 GERANIUM PLACE BALTO 20 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Anterior wall heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease, senile degeneration,</u> DUE TO (c) <u>bronchial pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Oct 57 TO 27 Oct 57</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 Oct 1957</u> , to <u>27 Oct 1957</u> , that I last saw the deceased alive on <u>27 Oct 1957</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>Azulesville, Md</u> DATE SIGNED <u>27 Oct 57</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL, Jr</u>				<u>SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 1 1957

BUREAU V. B.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

Reg. Dist. No.

STATE OF MARYLAND

WESTMONT

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

CERTIFICATE OF DEATH

10500

Reg. Dist. No. 26

10470

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>40 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>228 E. MAIN ST.</u>				d. STREET ADDRESS <u>228 E. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE VIOLETTA QUINN</u>				4. DATE OF DEATH Month Day Year <u>OCT. 4TH 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOT KNOWN</u>	
9. AGE (In years last birthday) <u>75?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DAVID H. ZIMMERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE RING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>MR. BRICE P. QUINN, WESTMINSTER, MD.</u>			
17. INFORMANT <u>MR. BRICE P. QUINN, WESTMINSTER, MD.</u>				Address <u>228 E. MAIN ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> DUE TO <u>Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrolithiasis</u> DUE TO (c) <u>Several</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>10/27/50</u> <u>Several</u> <u>4/50</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March, 1957</u> to <u>Oct 4, 1957</u> , that I last saw the deceased alive on <u>Oct 2, 1957</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Speicher</u> M.D. <u>Westminster, Md.</u>				ADDRESS (Street, city or town, state) <u>10/5/57</u>			
DATE SIGNED <u>10/5/57</u>							
PHYSICIAN'S NAME (Type) <u>W. E. Speicher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 7, 57</u>		<u>WESTMINSTER CEM.</u>		<u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>10-6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>October 1, 1957</i>		6. TIME OF DEATH <i>10:15 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. DISEASE OR INJURY <i>Coronary Artery Disease</i>		10. MANNER OF DEATH <i>Natural</i>		11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John J. Smith</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

OCT 8 1957

RECEIVED

10502

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick- Rural RD#6 10X22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Meadow Road			
3. NAME OF DECEASED (Type or print) First ALLEN Middle BENEDICT Last RAY				4. DATE OF DEATH Month October Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-29-69		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Yunk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Ray				14. MOTHER'S MAIDEN NAME Fannie Lease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yunk		17. INFORMANT Springfield State Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 491X (b) Bronchopneumonia, right. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholic Psychosis, Acute Hallucinosis.							INTERVAL BETWEEN ONSET AND DEATH Years 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-18- , 19 35 , to 10-15 , 19 57 , that I last saw the deceased alive on 10-15 , 19 57 , and that death occurred at 12:02PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 10-16-57							
ACTUAL SIGNATURE Martin Gross				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Martin Gross, M. D.				Sykesville, Maryland 10-16-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 10-16-57		24b. REGISTRAR'S SIGNATURE C. Henry Eblaw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10502 74

10503

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Hagerstown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 29 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE H		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle J Last REEVES		4. DATE OF DEATH Month OCT. Day 17 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1878
9. AGE (In years, last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 17 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES JONES		14. MOTHER'S MAIDEN NAME EMMA SHEPHERD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORD AT SPRINGFIELD S.H.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY INSUFFICIENCY 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) INVOLUTIONAL MELANCHOLIA		INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR 28, 1928 to OCT 17, 1957 , that I last saw the deceased alive on OCT 17, 1957 , and that death occurred at 3:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Gertrud Sonnenfeldt H.D. Springfield State Hospital Sykesville Md.			
PHYSICIAN'S NAME (Type) Gertrud SONNENFELD H.D. Springfield State Hospital Sykesville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/57	
22c. NAME OF CEMETERY OR CREMATORY Cold Spring Cemetery		22d. LOCATION (City, town, or county) (State) Cold Spring, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		24a. REC'D BY REGISTRAR Oct 19-57	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Harry H. Hays	

OCT 22 1957

RECEIVED

1

M

15

1

0

2

1

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

CERTIFICATE OF DEATH

10503

Reg. Dist. No. 1/4

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 9-22-36			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2			
3. NAME OF DECEASED (Type or print) First Casper Middle - Last REICHERT				4. DATE OF DEATH Month October Day 28 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 77 ? yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY -- Unk		11. BIRTHPLACE (State or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unkn.				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records of Springfield State Hospital				Address Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x (b) Bronchopneumonia, left lung DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH years 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tabo Paresis 025X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from Sept. 1 , 19 47 , to Oct. 28 , 19 57 , that I last saw the deceased alive on Oct. 28 , 19 57 , and that death occurred at 8:16 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/29/57							
ACTUAL SIGNATURE Ellis S. Margolin M.D.				PHYSICIAN'S NAME (Type) ELLIS S. MARGOLIN M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-1-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Krain ADDRESS Hagerstown, Md				24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE C. Harry Zuer	

RECEIVED

NOV 1 1957

BUREAU V. 11

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF CLERK	
21. SIGNATURE OF SHERIFF		22. SIGNATURE OF DEPUTY SHERIFF	
23. SIGNATURE OF CONSTABLE		24. SIGNATURE OF DEPUTY CONSTABLE	
25. SIGNATURE OF TOWNSHIP CLERK		26. SIGNATURE OF COUNTY CLERK	
27. SIGNATURE OF STATE CLERK		28. SIGNATURE OF FEDERAL CLERK	
29. SIGNATURE OF POSTAL CLERK		30. SIGNATURE OF TELEPHONE CLERK	
31. SIGNATURE OF RAILROAD CLERK		32. SIGNATURE OF AIRLINE CLERK	
33. SIGNATURE OF MARINE CLERK		34. SIGNATURE OF NAVY CLERK	
35. SIGNATURE OF ARMY CLERK		36. SIGNATURE OF AIR FORCE CLERK	
37. SIGNATURE OF SPACE CLERK		38. SIGNATURE OF DEFENSE CLERK	
39. SIGNATURE OF INTELLIGENCE CLERK		40. SIGNATURE OF SECURITY CLERK	
41. SIGNATURE OF POLICE CLERK		42. SIGNATURE OF PROSECUTOR CLERK	
43. SIGNATURE OF JUDGE CLERK		44. SIGNATURE OF CLERK OF COURT	
45. SIGNATURE OF CLERK OF LEGISLATURE		46. SIGNATURE OF CLERK OF SENATE	
47. SIGNATURE OF CLERK OF HOUSE OF REPRESENTATIVES		48. SIGNATURE OF CLERK OF SUPREME COURT	
49. SIGNATURE OF CLERK OF SUPREME COURT		50. SIGNATURE OF CLERK OF SUPREME COURT	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2513 N. Charles Street	
3. NAME OF DECEASED (Type or print) First Irma Middle Lee Last Wimbrow RICHARDSON		4. DATE OF DEATH Month October Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1890
9. AGE (In years less birthday) yrs. 67		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stansburg Wimbrow		14. MOTHER'S MAIDEN NAME Martha Godfrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-5364B	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung pending microscopic findings DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. - Rheumatic heart disease.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 29, 1957 , to October 9, 1957 , that I last saw the deceased alive on October 9, 1957 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/10/57			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10-12-57	Morland Park	Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		24a. REC'D BY REGISTRAR DATE 10-10-57	
ADDRESS 1317 N. Mount St. Balto.		24b. REGISTRAR'S SIGNATURE C. Harry Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. HENRY		MALE		65		JAN 1 1892		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		MARRIED		DATE OF MARRIAGE		JUN 15 1915		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		LABORER		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
PLACE OF DEATH		NEW YORK		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		HEART DISEASE		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
MANNER OF DEATH		NATURAL		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		JAMES J. HENRY		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		JAMES J. HENRY		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF WITNESS		JAMES J. HENRY		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF DECEASED		JAMES J. HENRY		DATE OF DEATH		OCT 14 1957		NEW YORK		NEW YORK		NEW YORK	

BUREAU V. F.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10505

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 1yr. 1mo. 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS RFD #2	
3. NAME OF DECEASED (Type or print) Alta Kate Gardner RIDENOUR		4. DATE OF DEATH Month October Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Postmistress		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George C. Gardner		14. MOTHER'S MAIDEN NAME Amanda Bidle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease with mitral and aortic stenosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. - - 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 10/15/57	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10/18/1957	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co.,		24a. REC'D BY REGISTRAR 21 1957	
ADDRESS Middletown, Md.		24b. REGISTRAR'S SIGNATURE <i>Cherry Heep</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 21 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10506 16

10507

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster Road		d. STREET ADDRESS Westminster Road	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Rook		4. DATE OF DEATH Month Oct. Day 26 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1876
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Rook		14. MOTHER'S MAIDEN NAME Sarah Ritter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Emory D. Rook, Finksburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C-V Disease DUE TO (c) 7 yrs.		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, left		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. no 19 p. m.		20d. INJURY OCCURRED While Not while of work of work none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 1-8-48 , 19____, to 10-26-57 , 19____, that I last saw the deceased alive on 10-22-57 , 19____, and that death occurred at 10:10M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Z. Z. Caples		ADDRESS (Street, city or town, state) DATE SIGNED 6 Hanover Rd. 10-28-57	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29/57	
22c. NAME OF CEMETERY OR CREMATORY St. Paul United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Myersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 10-28-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline Harriet M. Eline	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Date of Death 10-30-57		Place of Death Baltimore, Md.	
Decedent's Name [Illegible]		Sex Male	
Date of Birth 10-15-1917		Race White	
Usual Residence [Illegible]		Cause of Death [Illegible]	
Occupation [Illegible]		Manner of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Report 10-30-57		County Baltimore	

RECEIVED
 OCT 30 1957
 BUREAU V. 3

10508 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		10507	
Item 3: G 222 10/28/57 L		CERTIFICATE OF DEATH	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS
c. LENGTH OF STAY IN 1b	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	5. SEX	6. COLOR OR RACE
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1956, to Oct. 6, 1957, that I last saw the deceased alive on Oct. 6, 1957, and that death occurred at 10:55 P.M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE	PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	

BUREAU V. B.

OCT 14 1957

BUREAU V. B.

10509

CERTIFICATE OF DEATH

10508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20 yrs. 11 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d. STREET ADDRESS 1709 N. Wolfe st.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle Christian Last Schmitt				4. DATE OF DEATH Month October Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 20-1882	
9. AGE (In years birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Schmitt				14. MOTHER'S MAIDEN NAME Mary Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X not DUE TO Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (c) Epilepsy without psychosis				INTERVAL BETWEEN ONSET AND DEATH Days years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy without psychosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-16- 19 57 , to 10-27- 19 57 , that I last saw the deceased alive on 10-27- 19 57 , and that death occurred at 4.23 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo.				ADDRESS (Street, city or town, state) Springfield State Hospital.			
DATE SIGNED 10-27-57							
PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elsworth Armistead				24. REGISTRAR'S SIGNATURE C. Harry Weer			
ADDRESS 4600 Liberty Heights Avenue				DATE 31 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		Male		45		Jan 15, 1910		Baltimore, Md.	
MARRIAGE		MARRIED		DATE		PLACE		BY WHOM	
Married		Married		Jan 15, 1910		Baltimore, Md.		John A. Smith	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
Teacher		Teacher		Teacher		Teacher		Teacher	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
High School		High School		High School		High School		High School	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural		Natural		Natural		Natural	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957	

RECEIVED
OCT 31 1957
BUREAU V. S.

10510

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7 y 1 m 24 d			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16, Md.				d. STREET ADDRESS 3010 Littleton Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Schoenrock Last Schoenrock				4. DATE OF DEATH Month 10 Day 11 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-2-72		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber		10b. KIND OF BUSINESS OR INDUSTRY Hair Cutting		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Schoenrock				14. MOTHER'S MAIDEN NAME Mary Volhardt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 44-1-1111		17. INFORMANT S.S. Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 491 x Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis-Agitated depressed Type							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20 , 19 54 , to 10-11-57 , 19 57 , that I last saw the deceased alive on 10-11- , 19 57 , and that death occurred at 11 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 10-12-57	
PHYSICIAN'S NAME (Type) Edmund Lusthaus				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-57		22c. NAME OF CEMETERY OR CREMATORY St. John		22d. LOCATION (City, town, or county) (State) Howard Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Hight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 10-12-57	
				24b. REGISTRAR'S SIGNATURE C. H. Hight			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 13

OCT 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10511

CERTIFICATE OF DEATH

Reg. Dist. No.

105104

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY /Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 months 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First May Middle Sheckells Last Sheckells				4. DATE OF DEATH Month 10- Day 26 Year 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Sheckells				14. MOTHER'S MAIDEN NAME Jane Minifee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unkn			
17. INFORMANT Mrs. Lillian Penn				Address 3515 Meadows Rd. #7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cholecystitis 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 585X DUE TO (c) 585X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis with psych. reactions							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-30- 19 57 , to 10-25- 19 57 , that I last saw the deceased alive on 10-25- 19 57 , and that death occurred at 6:36 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-26-57							
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital							
PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS				24a. REC'D BY REGISTRAR DATE 10/30/57			
24b. REGISTRAR'S SIGNATURE C. Harry Sharp							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES J. JONES		M		35		W		10/10/1957		BOSTON, MASS.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
LABORER		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. MARITAL STATUS		16. EDUCATION		17. RELIGION		18. PREVIOUS ILLNESS	
NEW YORK		10/10/1922		MARRIED		HIGH SCHOOL		CATHOLIC		NONE	

BUREAU V. B.

OCT 31 1957

RECEIVED

10512

CERTIFICATE OF DEATH

105174
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libertytown 10 X 2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Mariah Last SMITH				4. DATE OF DEATH Month October Day 4 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 19, 1862		9. AGE (In years lost birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) Interval between onset and death one week plus Years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, simple deterioration in a schizophrenic of long standing.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to October 4, 1957 , that I last saw the deceased alive on October 4, 1957 , and that death occurred at 9:20A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 10/4/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-8-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Howell, Sykesville, Md.				24a. REC'D BY REGISTRAR C. Harry Myers		24b. REGISTRAR'S SIGNATURE C. Harry Myers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		TREATMENT		POST-MORTEM	
APRIL 4 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS OF THE CHEST AND BACK		NO PREVIOUS DISEASES		NO TREATMENT		NO POST-MORTEM	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE		ADDRESS		CITY		STATE		COUNTRY	
APRIL 4 1968		MEMPHIS, TENNESSEE		DR. JAMES H. HAYES		PHYSICIAN		1000 SOUTH MAIN STREET		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF SIGNATURE		PLACE OF SIGNATURE		SIGNATURE		TITLE		ADDRESS		CITY		STATE		COUNTRY	
APRIL 4 1968		MEMPHIS, TENNESSEE		JAMES H. HAYES		PHYSICIAN		1000 SOUTH MAIN STREET		MEMPHIS		TENNESSEE		UNITED STATES	

BUREAU V. B

APR 10 1968

RECEIVED

10513

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 187 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS R.F.D. 2, Box 380	
3. NAME OF DECEASED (Type or print) First Louis Middle Stepney, Jr. Last Stepney, Jr.		4. DATE OF DEATH Month October Day 30 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1868
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) A. A. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Stepney		14. MOTHER'S MAIDEN NAME Janie Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Louis Stepney, Jr. - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arterio-sclerosis DUE TO (c) Prostatic Hypertrophy			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 26, 1957 , to October 30, 1957 , that I last saw the deceased alive on October 30, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. Maculans		ADDRESS (Street, city or town, state) Henryton, Maryland	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.; Supt.		DATE SIGNED 10-30-57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Nov. 3/57	22c. NAME OF CEMETERY OR CREMATORY Broadneck	22d. LOCATION (City, town, or county) (State) St. Margarets Md
23. FUNERAL DIRECTOR'S SIGNATURE J. R. ... ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE 10-30-57	24b. REGISTRAR'S SIGNATURE Albert R. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - BATTLE ROCK, WY

1. NAME OF DECEASED J. H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH October 31, 1957	
5. PLACE OF DEATH Home		6. COUNTY Fremont		7. CITY Cheyenne		8. STATE Wyoming	
9. MARITAL STATUS Married		10. OCCUPATION Retired		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF WITNESS J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris		16. SIGNATURE OF WITNESS J. H. Harris	
17. SIGNATURE OF DECEASED J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris		19. SIGNATURE OF DECEASED J. H. Harris		20. SIGNATURE OF WITNESS J. H. Harris	
21. SIGNATURE OF DECEASED J. H. Harris		22. SIGNATURE OF WITNESS J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris	
25. SIGNATURE OF DECEASED J. H. Harris		26. SIGNATURE OF WITNESS J. H. Harris		27. SIGNATURE OF DECEASED J. H. Harris		28. SIGNATURE OF WITNESS J. H. Harris	
29. SIGNATURE OF DECEASED J. H. Harris		30. SIGNATURE OF WITNESS J. H. Harris		31. SIGNATURE OF DECEASED J. H. Harris		32. SIGNATURE OF WITNESS J. H. Harris	
33. SIGNATURE OF DECEASED J. H. Harris		34. SIGNATURE OF WITNESS J. H. Harris		35. SIGNATURE OF DECEASED J. H. Harris		36. SIGNATURE OF WITNESS J. H. Harris	
37. SIGNATURE OF DECEASED J. H. Harris		38. SIGNATURE OF WITNESS J. H. Harris		39. SIGNATURE OF DECEASED J. H. Harris		40. SIGNATURE OF WITNESS J. H. Harris	
41. SIGNATURE OF DECEASED J. H. Harris		42. SIGNATURE OF WITNESS J. H. Harris		43. SIGNATURE OF DECEASED J. H. Harris		44. SIGNATURE OF WITNESS J. H. Harris	
45. SIGNATURE OF DECEASED J. H. Harris		46. SIGNATURE OF WITNESS J. H. Harris		47. SIGNATURE OF DECEASED J. H. Harris		48. SIGNATURE OF WITNESS J. H. Harris	
49. SIGNATURE OF DECEASED J. H. Harris		50. SIGNATURE OF WITNESS J. H. Harris		51. SIGNATURE OF DECEASED J. H. Harris		52. SIGNATURE OF WITNESS J. H. Harris	
53. SIGNATURE OF DECEASED J. H. Harris		54. SIGNATURE OF WITNESS J. H. Harris		55. SIGNATURE OF DECEASED J. H. Harris		56. SIGNATURE OF WITNESS J. H. Harris	
57. SIGNATURE OF DECEASED J. H. Harris		58. SIGNATURE OF WITNESS J. H. Harris		59. SIGNATURE OF DECEASED J. H. Harris		60. SIGNATURE OF WITNESS J. H. Harris	
61. SIGNATURE OF DECEASED J. H. Harris		62. SIGNATURE OF WITNESS J. H. Harris		63. SIGNATURE OF DECEASED J. H. Harris		64. SIGNATURE OF WITNESS J. H. Harris	
65. SIGNATURE OF DECEASED J. H. Harris		66. SIGNATURE OF WITNESS J. H. Harris		67. SIGNATURE OF DECEASED J. H. Harris		68. SIGNATURE OF WITNESS J. H. Harris	
69. SIGNATURE OF DECEASED J. H. Harris		70. SIGNATURE OF WITNESS J. H. Harris		71. SIGNATURE OF DECEASED J. H. Harris		72. SIGNATURE OF WITNESS J. H. Harris	
73. SIGNATURE OF DECEASED J. H. Harris		74. SIGNATURE OF WITNESS J. H. Harris		75. SIGNATURE OF DECEASED J. H. Harris		76. SIGNATURE OF WITNESS J. H. Harris	
77. SIGNATURE OF DECEASED J. H. Harris		78. SIGNATURE OF WITNESS J. H. Harris		79. SIGNATURE OF DECEASED J. H. Harris		80. SIGNATURE OF WITNESS J. H. Harris	
81. SIGNATURE OF DECEASED J. H. Harris		82. SIGNATURE OF WITNESS J. H. Harris		83. SIGNATURE OF DECEASED J. H. Harris		84. SIGNATURE OF WITNESS J. H. Harris	
85. SIGNATURE OF DECEASED J. H. Harris		86. SIGNATURE OF WITNESS J. H. Harris		87. SIGNATURE OF DECEASED J. H. Harris		88. SIGNATURE OF WITNESS J. H. Harris	
89. SIGNATURE OF DECEASED J. H. Harris		90. SIGNATURE OF WITNESS J. H. Harris		91. SIGNATURE OF DECEASED J. H. Harris		92. SIGNATURE OF WITNESS J. H. Harris	
93. SIGNATURE OF DECEASED J. H. Harris		94. SIGNATURE OF WITNESS J. H. Harris		95. SIGNATURE OF DECEASED J. H. Harris		96. SIGNATURE OF WITNESS J. H. Harris	
97. SIGNATURE OF DECEASED J. H. Harris		98. SIGNATURE OF WITNESS J. H. Harris		99. SIGNATURE OF DECEASED J. H. Harris		100. SIGNATURE OF WITNESS J. H. Harris	

BUREAU V. E.

OCT 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>306 East 32nd Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Rea</u> Last <u>Tolson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unk</u>		9. AGE (In years last birthday) <u>70?</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rea</u>				14. MOTHER'S MAIDEN NAME <u>Anne E. -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT Address <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc with circ. dist. with cerebral arteriosclerosis, with psycho-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>tic reaction</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>November 2, 1956</u> , to <u>October 21, 1957</u> , that I last saw the deceased alive on <u>October 21, 1957</u> , and that death occurred at <u>6:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elizabeth Kuyopp</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hosp, Sykesville</u>			
PHYSICIAN'S NAME (Type) <u>Elizabeth Kuyopp</u>				DATE SIGNED <u>Springfield State Hosp, Sykesville</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Calverton</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mearns</u> ADDRESS <u>805 N. Calverton St.</u>				24a. REC'D BY REGISTRAR DATE <u>10-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wace</u>	

[illegible]

10515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4y 8 m 28 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5, Md.			
3. NAME OF DECEASED (Type or print) First Margaret Middle Oversider Last Van Court				4. DATE OF DEATH Month 10- Day 26 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-67	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oversider				14. MOTHER'S MAIDEN NAME OVERSIDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT S.S.Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr.brain syndr.assoc.with cerebr.arterioscler.with dist.of circulation						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Oct. 20, 1954 to Oct. 26, 1957 that I last saw the deceased alive on 10-26-1957 and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-26-57 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
Burial	Oct. 29/57	Baltimore	Baltimore				
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		ADDRESS 2024 Orleans St	24a. REC'D BY REGISTRAR C. Harry Myers	24b. REGISTRAR'S SIGNATURE C. Harry Myers	DATE OCT 30 1957		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

10516

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1509 Forest Glen Road			
3. NAME OF DECEASED (Type or print) First Frederick Middle Stewart Last VERMILLION				4. DATE OF DEATH Month October Day 24 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1873	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage employee		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X X0006 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 17, 1957 , to October 24, 1957 , that I last saw the deceased alive on October 24, 1957 , and that death occurred at 2:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED. 10/24/57							
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE GEIER FUNERAL Home				ADDRESS 3605 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 28 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Heery			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

NAME OF DECEASED LAWSON		SEX Male		AGE 7 days	
DATE OF DEATH October 28, 1957		PLACE OF DEATH Home		CITY Baltimore	
HUSBAND LAWSON		WIFE LAWSON		CHILDREN LAWSON	
OCCUPATION LAWSON		EDUCATION LAWSON		RELIGION LAWSON	
CAUSE OF DEATH LAWSON		MANNER OF DEATH LAWSON		PLACE OF BURIAL LAWSON	
DATE OF BURIAL LAWSON		PLACE OF BURIAL LAWSON		CITY Baltimore	

NAME OF DECEASED LAWSON		SEX Male		AGE 7 days	
DATE OF DEATH October 28, 1957		PLACE OF DEATH Home		CITY Baltimore	
HUSBAND LAWSON		WIFE LAWSON		CHILDREN LAWSON	
OCCUPATION LAWSON		EDUCATION LAWSON		RELIGION LAWSON	
CAUSE OF DEATH LAWSON		MANNER OF DEATH LAWSON		PLACE OF BURIAL LAWSON	
DATE OF BURIAL LAWSON		PLACE OF BURIAL LAWSON		CITY Baltimore	

BUREAU Y. E.

OCT 28 1957

RECEIVED

NAME OF DECEASED LAWSON		SEX Male		AGE 7 days	
DATE OF DEATH October 28, 1957		PLACE OF DEATH Home		CITY Baltimore	
HUSBAND LAWSON		WIFE LAWSON		CHILDREN LAWSON	
OCCUPATION LAWSON		EDUCATION LAWSON		RELIGION LAWSON	
CAUSE OF DEATH LAWSON		MANNER OF DEATH LAWSON		PLACE OF BURIAL LAWSON	
DATE OF BURIAL LAWSON		PLACE OF BURIAL LAWSON		CITY Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1.
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G222 11-7-57 at
10517
CERTIFICATE OF DEATH

10516

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr, 1 mo, 22 dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28		0352.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 5743 Edmondson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Amanda Melvina Voyce		4. DATE OF DEATH Month Day Year October 22 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Roberts		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address Springfield hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30, 1956, to October 22, 1957, that I last saw the deceased alive on October 21, 1957, and that death occurred at 1:08 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE Elizabeth Knopp		ADDRESS (Street, city or town, state) Springfield State Hosp, Sykesville	
PHYSICIAN'S NAME (Type) Elizabeth Knopp		DATE SIGNED October 22, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Judy Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE NIV 1 1957	
24b. REGISTRAR'S SIGNATURE Harry Weer			

83

NOV 1 1957

RECEIVED

105175

10518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>BALTIMORE</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MANCHESTER</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>				d. STREET ADDRESS <i>4311 Grandview Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>GLENN</i> Middle <i>TB.</i> Last <i>WATERS</i>				4. DATE OF DEATH Month <i>October</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 17, 1885</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Contractor Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>West. Virginia</i>			
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George WATERS</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Williams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>216-45-9445</i>			
17. INFORMANT <i>Mr. Harold L. Waters - 4311 Grandview Ave.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-Sclerotic Cardio-Vascular Disease</i> DUE TO (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Parkinson's Disease</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>							
21. I certify that I attended the deceased from <i>Dec 11, 1954</i> , to <i>October 20, 1957</i> , that I last saw the deceased alive on <i>October 17, 1957</i> , and that death occurred at <i>4:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph E. Bush</i> M.D.				ADDRESS (Street, city or town, state) <i>Hampstead Md</i> DATE SIGNED <i>10-30-57</i>			
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush M.D.</i>				<i>HAMPSTEAD Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/23/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Pk.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WM. J. TICKNER & SONS - Balto. 17, Md.</i>				42a. REC'D BY REGISTRAR <i>BPP</i> DATE <i>10/24/57</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. M. L. Deane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Palapasco</u>	c. LENGTH OF STAY IN 1b <u>2 wks.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 Vol-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>363 S Conkling St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BERNARD F. WIENHOLD</u>	First Middle Last	4. DATE OF DEATH <u>Oct 15 1957</u>	Month Day Year
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-05</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HANDYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BERLET MEAT CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BERNARD WIENHOLD</u>		14. MOTHER'S MAIDEN NAME <u>SUSANNA GRESS.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>CATHERINE HUTH</u>		Address <u>1308 S. BAYLIS ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 10-18-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY CEN</u>		22d. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Zeiler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	
24a. REC'D BY REGISTRAR <u>Harriet Muller</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Muller</u>	

BUREAU V. 3

OCT 21 1957

RECEIVED

10520

CERTIFICATE OF DEATH

10519
Reg. Dist. No. 114

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 m 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 1522 E. Preston Street			
3. NAME OF DECEASED (Type or print) First Orange Middle Dillon Last Wolfe				4. DATE OF DEATH Month 10 Day 5 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-76	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Thomas Wolfe				14. MOTHER'S MAIDEN NAME Elizabeth Eley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) u n k n		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with cerebral arterioscler. with psych. reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-15-1957 , to 10-5-1957 , that I last saw the deceased alive on 10-5-57 , 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Edmund Lusthaus				M.D. Springfield State Hospital 10-5-57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-57		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cemetery		22d. LOCATION (City, town, or county) (State) E, kridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 10-5-57		24b. REGISTRAR'S SIGNATURE C. Henry Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10521

CERTIFICATE OF DEATH

10520

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 10mos. 23days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Charles Last WOLVERTON				4. DATE OF DEATH Month October Day 29 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1883	
9. AGE (In years birth day) 74		IF UNDER 1 YEAR Months 11 Days 22		IF UNDER 24 HRS. Hours 11 Min. 22			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Scott Wolverton				14. MOTHER'S MAIDEN NAME - Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 491x None Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH Days Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 6, 1956 to October 29, 1957 , that I last saw the deceased alive on October 29, 1957 , and that death occurred at 3:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/29/57							
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-57		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Oakland Garrett Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Baldwin Funeral Home - Oakland, Md.				24a. REC'D BY REGISTRAR DATE 10/30/57		24b. REGISTRAR'S SIGNATURE C. Navy	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		NOV 1 1927		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		BURIED		INTERMENT	
JAMES H. HARRIS		MARY H. HARRIS		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF INTERVIEW		BY		OFFICIAL		SIGNATURE		TITLE		OFFICE	
NOV 1 1927		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU Y. S.

NOV 1 1927

RECEIVED